

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

9092

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09047

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 2 yrs. 11 mos. 11 das.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rachel Middle Evelyn Last Bedwell		4. DATE OF DEATH Month August Day 4 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-27-06
9. AGE (In years lost birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Bowlsby		14. MOTHER'S MAIDEN NAME Mary Stephens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT Eastern Shore State Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxicity and shock DUE TO 450-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gangrene left lower extremity DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 6 days Sev. yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-21 11:55 p.m. to 8-4 19 60 , that (I) (we) last saw the deceased alive on 8-4 19 60 and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Simon Virkutis		22b. DATE SIGNED 8-5-60	
22c. PHYSICIAN'S NAME (Type) Simon Virkutis, M.D.		22d. ADDRESS E.S.S. Hospital, Cambridge, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/8/60	
23c. NAME OF CEMETERY OR CREMATORY Zion Cemetery		23d. LOCATION (City, town, or county) (State) Zion, Md. Cecil	
24. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		25a. REC'D BY REGISTRAR AUG 10 60	
ADDRESS Elkton, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Howard	

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CERTIFICATE OF DEATH

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9073

Item 9 Baltimore 9-1-60 at

CERTIFICATE OF DEATH

09048

1. PLACE OF DEATH a. COUNTY Dorchester, Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester, Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ethel Middle Bramble Last Brannock		4. DATE OF DEATH Month 8 Day 24 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/11/1883
9. AGE (In years last birthday) 78 76yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME H. Milbourne Bramble		14. MOTHER'S MAIDEN NAME Sally Mills	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mrs. Herbert Travers, Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause lost. (b) Gangrene right foot DUE TO (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 1 wk. 2 wks. ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/17/60 19 to 8/24/60 19, that (I) (we) last saw the deceased alive on 8/24/60 19, and that death occurred at 1 P. from the causes and on the date stated above.			
22a. SIGNATURE <i>John Mace Jr.</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) John Mace Jr.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/26/1960	
23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		23d. LOCATION (City, town, or county) (State) Cambridge, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.		25a. REC'D BY REGISTRAR DATE AUG 31 '60	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

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CERTIFICATE OF DEATH

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

9074

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09049

1. PLACE OF DEATH a. COUNTY <u>Dorchester, Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomac</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parksley, Virginia.</u>	
c. LENGTH OF STAY IN 1b <u>3 Weeks</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bay Heights, Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		83X-3	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Lee</u> Last <u>Budd</u>		4. DATE OF DEATH Month <u>8</u> Day <u>24</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/2/1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>24</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Presser</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shirt Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Accomac, Co. Virginia.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Thomas Colona</u>		14. MOTHER'S MAIDEN NAME <u>Mannie Hickman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>223-18-6805</u>	
17. INFORMANT <u>Mrs. Edward Budd, Cambridge, Md</u>		Address <u>Cambridge, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY DECOMPENSATION</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <u>ARTERIO SCLEROTIC HT. DISEASE</u> DUE TO (c) <u>UNKNOWN</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSION, ESSENTIAL</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/11</u> 19 <u>60</u> , to <u>8/24</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>6/30</u> 19 <u>60</u> , and that death occurred at <u>12:45</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Alfred R. Maryanov</u>		22b. ADDRESS <u>136 RALE ST, CAMBRIDGE, MD</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. MARYANOV</u>		22d. ADDRESS <u>136 RALE ST, CAMBRIDGE, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/26/1960.</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parksley Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Parsley, Virginia.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE AUG 31 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

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MEDICAL CERTIFICATION

9075

09050

1. PLACE OF DEATH o. COUNTY						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE					
Dorchester, Co.						Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Cambridge, Maryland.						13 Cambridge, Maryland.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						d. STREET ADDRESS					
200 Oakley, Street.						200 Oakley, Street.					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last						Month Day Year					
Robert T. Christopher						8 12 1960					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
Male		White				9/21/1878		88		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY					
Postal Clerk						U.S. Mail					
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Robert R. Christopher						Catharine Willey					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.					
No						Mrs. Marian North 200 Oakley St. Cambridge, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 293X Aplastic Anemia DUE TO Senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
Fibrosis Lungs											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from the causes and on the date stated above.											
22a. SIGNATURE						22b. DATE SIGNED					
W.H.H. Hawks						8/15/60					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
W.H.H. Hawks, M.D.						Cambridge Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE THEREOF					
Burial						8/15/1960					
23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION (City, town, or county) (State)					
Green Lawn Cemetery						Cambridge, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE						25a. REC'D BY REGISTRAR					
Le Compte Funeral Service. Cambridge, Md.						DATE AUG 23 '60					
						25b. REGISTRAR'S SIGNATURE					
						Caroline E. Hawk					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9093

CERTIFICATE OF DEATH

Reg. Dist. No. 09051

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsburg		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Charles Middle Wright Last Coulbourn , Sr.		4. DATE OF DEATH Month August Day 6 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 9, 1900
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 59 Days 59 Hours 59 Min.	11. IF UNDER 24 HRS. Months 59 Days 59 Hours 59 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Constable		10b. KIND OF BUSINESS OR INDUSTRY Dorchester Co., Md.	
11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles H. Coulbourn		14. MOTHER'S MAIDEN NAME Celia Harlock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-12-1527	
17. INFORMANT Mrs. Charles W. Coulbourn, Sr., Williamsburg,		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute left Ventricular Cardiac failure 420.1 DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Due to Generalized Arteriosclerosis DUE TO (c) Acute viral infection preceded thrombosis by about 4 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute viral infection preceded thrombosis by about 4 days INTERVAL BETWEEN ONSET AND DEATH 2 hrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-4 , 19 60 , to 8-6 , 19 60 that I last saw the deceased alive on 8-6 , 19 60 , and that death occurred at 1:15 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Preston, Maryland DATE SIGNED Preston Md ACTUAL SIGNATURE Dr. H. B. Plummer M.D. Preston Md PHYSICIAN'S NAME (Type) Dr. H. B. Plummer			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 8, 1960	
22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		22d. LOCATION (City, town, or county) (State) Federalburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalburg, Maryland		24a. REC'D BY REGISTRAR DATE AUG 11 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

(M)

(1)

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Time of death: _____

8. Cause of death: _____

9. Signature of physician: _____

10. Signature of registrar: _____

11. Date of registration: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be attached with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9076

CERTIFICATE OF DEATH

Reg. Dist. No. 09053

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>105 Washington Street</u>				d. STREET ADDRESS <u>105 Washington Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Gladys</u> Middle <u>Foster</u> Last <u>Foster</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 15, 1886</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester County, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>William Foster</u>			
14. MOTHER'S MAIDEN NAME <u>Josephine Stanley</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>219-18-0092</u>				17. INFORMANT <u>William Foster, Church Creek, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>July 1, 1959</u> , to <u>August 15, 1960</u> , that I last saw the deceased alive on <u>August 15, 1960</u> and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>227 pine st-Cambridge, Md.</u>				DATE SIGNED <u>8-19-60</u>			
ACTUAL SIGNATURE <u>J. Edwin Fassett</u>				M.D. <u>J. Edwin Fassett, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8/21/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Crapo Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Crapo, Dor. Co., Maryland</u>				22e. REC'D BY REGISTRAR DATE <u>AUG 23 '60</u>			
22f. REGISTRAR'S SIGNATURE <u>Arthur S. Farris</u>				22g. REGISTRAR'S SIGNATURE <u>Arthur S. Farris</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **09054**

9077

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY Dor.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) William Andrew Gemeny		4. DATE OF DEATH 8/12/1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/23/1896
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Charge H.A.A.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stephen Gemeny		14. MOTHER'S MAIDEN NAME Annig Grace	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 000-00-0000	
17. INFORMANT Mrs. H.A. Gemeny		Address East New Market	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Infarction DUE TO Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Arteriosclerotic Cardiovascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Previous Coronary Infarction - Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 10 years	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7-29-1960 , to 8-2-1960 , that I last saw the deceased alive on 8-1-1960 , and that death occurred at 1:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Barndon		DATE SIGNED 8-2-60	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 8/4/60	22c. NAME OF CEMETERY OR CREMATORY East New Market	22d. LOCATION (City, town, or county) (State) East New Market, MD
23. FUNERAL DIRECTOR'S SIGNATURE Arthur M. Moxley		ADDRESS East New Market	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	
DATE AUG 4 '60			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 10-1-57

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
SEX		RACE	
MARRIAGE		EDUCATION	
OCCUPATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH	
IMMEDIATE CAUSE		INTERMEDIATE CAUSE	
FUNDAMENTAL CAUSE		PRE-EXISTING DISEASES	
SIGNS AND SYMPTOMS		TREATMENT	
HISTORY		FAMILY HISTORY	
SOCIAL HISTORY		HISTORICAL DATA	
PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS	
PATHOLOGICAL FINDINGS		MICROSCOPIC FINDINGS	
GROSS FINDINGS		HISTOLOGICAL FINDINGS	
TOPOGRAPHIC FINDINGS		CYTOLOGICAL FINDINGS	
BACTERIOLOGICAL FINDINGS		SEROLOGICAL FINDINGS	
IMMUNOLOGICAL FINDINGS		GENETIC FINDINGS	
RADIOLOGICAL FINDINGS		OTHER FINDINGS	
POST-MORTEM FINDINGS		AUTOPSY FINDINGS	
FORENSIC FINDINGS		TOXICOLOGICAL FINDINGS	
ANTHROPOLOGICAL FINDINGS		DENTAL FINDINGS	
ENTOMOLOGICAL FINDINGS		BOTANICAL FINDINGS	
ZOOLOGICAL FINDINGS		MINERALOGICAL FINDINGS	
METEOROLOGICAL FINDINGS		ASTRONOMICAL FINDINGS	
GEOLOGICAL FINDINGS		HYDROLOGICAL FINDINGS	
COSMOLOGICAL FINDINGS		OTHER FINDINGS	

1. Name of the deceased: _____

2. Date of death: _____

3. Place of death: _____

4. Age: _____

5. Sex: _____

6. Race: _____

7. Marriage: _____

8. Education: _____

9. Occupation: _____

10. Religion: _____

11. Cause of death: _____

12. Manner of death: _____

13. Immediate cause: _____

14. Intermediate cause: _____

15. Fundamental cause: _____

16. Signs and symptoms: _____

17. History: _____

18. Social history: _____

19. Physical examination: _____

20. Laboratory examinations: _____

21. Pathological findings: _____

22. Microscopic findings: _____

23. Gross findings: _____

24. Topographic findings: _____

25. Bacteriological findings: _____

26. Immunological findings: _____

27. Radiological findings: _____

28. Post-mortem findings: _____

29. Forensic findings: _____

30. Anthropological findings: _____

31. Entomological findings: _____

32. Botanical findings: _____

33. Zoological findings: _____

34. Mineralogical findings: _____

35. Meteorological findings: _____

36. Astronomical findings: _____

37. Geological findings: _____

38. Hydrological findings: _____

39. Cosmological findings: _____

40. Other findings: _____

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9094 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09055

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 2 yrs. 7 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital				d. STREET ADDRESS 114 Vue de l'Eau St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Elmer Groff, Sr.				4. DATE OF DEATH Month August Day 4 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 31, 1880		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman		10b. KIND OF BUSINESS OR INDUSTRY Lancaster, Pa.		11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Elias Groff				14. MOTHER'S MAIDEN NAME Mary Ann Herr			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-8693		17. INFORMANT Mrs. Estelle J. Groff, 114 Vue de l'Eau St. Cambridge,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) ?						INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Mace Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) John Mace Jr.				DATE SIGNED 4/5/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 6, 1960		22c. NAME OF CEMETERY OR CREMATORY Christ Church Cemetery		22d. LOCATION (City, town, or country) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR Benneth R. Showers				ADDRESS Cambridge, Md.			
24a. REC'D BY REGISTRAR AUG 10 1960				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

THE STATE
HOSPITAL

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Admission

Eastern Shore State Hospital

Label

Size

Medical Division

Room 201

Admission

Discharge

Admission

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9095

CERTIFICATE OF DEATH

09056

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b 5mos. 10das.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				d. STREET ADDRESS Smith Island			
3. NAME OF DECEASED (Type or print) First William Middle Henry Last Guy				4. DATE OF DEATH Month August Day 19 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-24-89	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired waterman				10b. KIND OF BUSINESS OR INDUSTRY - SEAFOOD		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Guy				14. MOTHER'S MAIDEN NAME Rachel Crockett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) W.W. I		16. SOCIAL SECURITY NO. 231-14-3666		17. INFORMANT Eastern Shore State Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 hr. 2yrs.+	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7-17- , 1959 , to 8-19 , 1960 , that I last saw the deceased alive on 8-19 , 1960 , and that death occurred at 3:30P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE George H. Longley M.D.				Eastern Shore State Hospital Cambridge, Maryland 8-19-60			
PHYSICIAN'S NAME (Type) George H. Longley, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-21-60		22c. NAME OF CEMETERY OR CREMATORY EWELL CEMETERY		22d. LOCATION (City, town, or county) (State) EWELL MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons				ADDRESS Crisfield Md.		24a. REC'D BY REGISTRAR DATE AUG 23 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

9096

09057

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CAMBRIDGE</u>				c. LENGTH OF STAY IN 1b <u>4 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSP.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE DAVIS HAMMOND</u>				4. DATE OF DEATH Month Day Year <u>AUGUST 8 1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 19, 1894</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE DAVIS</u>				14. MOTHER'S MAIDEN NAME <u>MATTIE DUBERRY DAVIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		INFORMANT Address <u>EVELYN JUSTICE ELKTON, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHO-PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) DUE TO (c) 491X							INTERVAL BETWEEN ONSET AND DEATH <u>8 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JULY 1, 1959</u> , to <u>AUG. 8, 1960</u> , that I last saw the deceased alive on <u>AUG. 7, 1960</u> , and that death occurred at <u>3:40 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George H. Longley</u>				ADDRESS (Street, city or town, state) <u>CAMBRIDGE, MD.</u> DATE SIGNED <u>8/8/60</u>			
PHYSICIAN'S NAME (Type) <u>GEORGE H. LONGLEY</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/11/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CHERRY HILL</u>		22d. LOCATION (City, town, or county) (State) <u>CHERRY HILL, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>N.H. Paffin Funeral Home</u>				ADDRESS <u>W.C. Leach Elkton MD</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 11 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Paine</u>			

00000

CERTIFICATE OF DEATH

30000



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester, Co MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester, Co			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 19 Muir, Street				e. STREET ADDRESS 19 Muir, Street			
3. NAME OF DECEASED (Type or print) First Middle Last Charles E. Harper				4. DATE OF DEATH Month Day Year 8 7 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/19/1890		9. AGE (In years last birthday) yrs. 70		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber			10b. KIND OF BUSINESS OR INDUSTRY Plumber		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Harper				14. MOTHER'S MAIDEN NAME Elizabeth Dunn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 159-05-1307		17. INFORMANT Mrs Charles Harper, 19 Muir, St. Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 days 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8/13/60 , 19 60 , to 8/16/60 , 19 60 , that I last saw the deceased alive on 8/16/60 , 19 60 , and that death occurred at 5:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Lawrence Maryanov M.D.				ADDRESS (Street, city or town, state) 136 Race St. Cambridge, Md			
DATE SIGNED 8/9/60							
PHYSICIAN'S NAME (Type) Lawrence Maryanov							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/9/1960		22c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery		22d. LOCATION (City, town, or county) (State) East New Market, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.				ADDRESS Le Compte Funeral Service, Cambridge, Md.		24a. REC'D BY REGISTRAR AUG 23 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Knap			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00038

CERTIFICATE OF DEATH

807

NAME OF DECEASED <i>John Doe</i>		LOCALITY <i>Baltimore, Md.</i>	
AGE <i>45</i>		SEX <i>Male</i>	
DATE OF BIRTH <i>Jan 1, 1900</i>		PLACE OF BIRTH <i>Baltimore, Md.</i>	
OCCUPATION <i>Teacher</i>		CAUSE OF DEATH <i>Heart Disease</i>	
DATE OF DEATH <i>Dec 15, 1945</i>		PLACE OF DEATH <i>Home</i>	
TIME OF DEATH <i>10:30 AM</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF PHYSICIAN <i>John Doe</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>	
DATE OF SIGNATURE <i>Dec 15, 1945</i>		DATE OF SIGNATURE <i>Dec 15, 1945</i>	
PLACE OF SIGNATURE <i>Baltimore, Md.</i>		PLACE OF SIGNATURE <i>Baltimore, Md.</i>	
SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>	
DATE OF SIGNATURE <i>Dec 15, 1945</i>		DATE OF SIGNATURE <i>Dec 15, 1945</i>	
PLACE OF SIGNATURE <i>Baltimore, Md.</i>		PLACE OF SIGNATURE <i>Baltimore, Md.</i>	
SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>	
DATE OF SIGNATURE <i>Dec 15, 1945</i>		DATE OF SIGNATURE <i>Dec 15, 1945</i>	
PLACE OF SIGNATURE <i>Baltimore, Md.</i>		PLACE OF SIGNATURE <i>Baltimore, Md.</i>	

9097

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09059

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Dor MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Ind. b. COUNTY Dor

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shulock c. LENGTH OF STAY IN TB Shulock c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shulock

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1 e. STREET ADDRESS Rural e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Frank Middle Henry Last Henry 4. DATE OF DEATH Month 8 Day 9 Year 1960

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH Approx. 76 yrs. 9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR Months 7 Days 18 IF UNDER 24 HRS. Hours 18 Min. 18

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer 10b. KIND OF BUSINESS OR INDUSTRY Maryland 11. BIRTHPLACE (State or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Henry 14. MOTHER'S MAIDEN NAME Mary Collins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) Ellie Henry Federal St. Md. 16. SOCIAL SECURITY NO. Ellie Henry Federal St. Md. 17. INFORMANT Address Ellie Henry Federal St. Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
DUE TO 420.1
Conditions, if any, which gave rise to immediate cause (b) 420.1
(a), stating the underlying cause lost. DUE TO (c) 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED White ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) East New Market 20f. (City or town) East New Market (County) Ind. (State) Ind.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE John Mace Jr. M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 8/18/60
EXAMINER'S NAME (Type) John Mace Jr. ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 8/18/60 22c. NAME OF CEMETERY OR CREMATORY East New Market 22d. LOCATION (City, town, or county) East New Market (State) Ind.

23. FUNERAL DIRECTOR'S SIGNATURE W. S. Hillocky, Jr. ADDRESS East New Market 24a. REC'D BY REGISTRAR DATE AUG 26 '60 24b. REGISTRAR'S SIGNATURE Charles S. Frank

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____	
SEX _____	
AGE _____	
DATE OF DEATH _____	
PLACE OF DEATH _____	
OCCUPATION _____	
CAUSE OF DEATH _____	
MANNER OF DEATH _____	
SIGNATURE OF MEDICAL EXAMINER _____	
DATE OF SIGNATURE _____	
SIGNATURE OF WITNESS _____	
DATE OF SIGNATURE _____	

100
 1

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9079 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09060

1. PLACE OF DEATH a. COUNTY Dorchester, Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester, Co.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland.				c. LENGTH OF STAY IN 1b 20 Years			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 529 Oakley, Street.				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland.			
				d. STREET ADDRESS 529 Oakley, Street.			
3. NAME OF DECEASED (Type or print) George W. Hubbard				4. DATE OF DEATH Month 8 Day 16 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/5/1864.	
9. AGE (In years last birthday) 96 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farmer			
11. BIRTHPLACE (State or foreign country) Maryland.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles Hubbard				14. MOTHER'S MAIDEN NAME Anna Kirwan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. No			
17. INFORMANT Mr. William Hubbard, Cambridge, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 8/17/60 DATE SIGNED ACTUAL SIGNATURE John Mace Jr. M.D. EXAMINER'S NAME (Type) John Mace Jr. M.D. Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/19/1960.		22c. NAME OF CEMETERY OR CREMATORY Lowden Park Cemetery		22d. LOCATION (City, town, or country) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR Le Compte Funeral Service, Cambridge, Md.				24a. REC'D BY REGISTRAR AUG 23 '60			
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

NEW STATE
BIRTH



Registration No.

Birth Date

322 Childs Street

Room 2

Life

1917

Charles Richard

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Registration No.

Birth Date

322 Childs Street

Room 2

Life

1917

Charles Richard

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Registration No.

Birth Date

322 Childs Street

Room 2

Life

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Charles Richard

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Registration No.

Birth Date

322 Childs Street

Room 2

Life

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Charles Richard

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9098

CERTIFICATE OF DEATH

Reg. Dist. No.

09061

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b 6yr.6mo.17das			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				e. STREET ADDRESS 306 West End Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Frances Middle B. Last Hubbert				4. DATE OF DEATH Month August Day 19 Year 1960			
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-73		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 8 Days 19 Hours 19 Min.	IF UNDER 24 HRS. Months 8 Days 19 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Stewart				14. MOTHER'S MAIDEN NAME Susan Billups			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. -			
17. INFORMANT Records - Eastern Shore State Hospital				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) several years						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. n. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb. 54 to August 60 , that I last saw the deceased alive on August 19 1960 , and that death occurred at 4:40 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Simon Virkutis				ADDRESS (Street, city or town, state) E.S.S. Hospital, Cambridge, Md.			
DATE SIGNED 8-19-60							
PHYSICIAN'S NAME (Type) Dr. Simon Virkutis							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-21-60		22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Home, Cambridge, Md.				ADDRESS		24a. REC'D BY REGISTRAR AUG 23 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

9083

COUNTY OF BALTIMORE CITY OF BALTIMORE		DECEASED JAMES J. COUGHLIN	
PLACE OF BIRTH NEW YORK		DATE OF BIRTH JANUARY 1, 1890	
PLACE OF DEATH BALTIMORE		DATE OF DEATH JANUARY 1, 1940	
TIME OF DEATH 10:00 AM		CAUSE OF DEATH CORONARY ARTERIOSCLEROSIS	
PLACE OF INTERMENT GREEN HILLS		NAME OF FUNERAL HOME JAMES J. COUGHLIN	
NAME OF PHYSICIAN JAMES J. COUGHLIN		NAME OF HOSPITAL BALTIMORE CITY STATE HOSPITAL	
NAME OF NURSE JAMES J. COUGHLIN		NAME OF ASSISTANT JAMES J. COUGHLIN	
NAME OF ATTENDING PHYSICIAN JAMES J. COUGHLIN		NAME OF ASSISTANT PHYSICIAN JAMES J. COUGHLIN	
NAME OF PATHOLOGIST JAMES J. COUGHLIN		NAME OF ASSISTANT PATHOLOGIST JAMES J. COUGHLIN	
NAME OF BACTERIOLOGIST JAMES J. COUGHLIN		NAME OF ASSISTANT BACTERIOLOGIST JAMES J. COUGHLIN	
NAME OF RADIOLOGIST JAMES J. COUGHLIN		NAME OF ASSISTANT RADIOLOGIST JAMES J. COUGHLIN	
NAME OF ANATOMIST JAMES J. COUGHLIN		NAME OF ASSISTANT ANATOMIST JAMES J. COUGHLIN	
NAME OF HISTOLOGIST JAMES J. COUGHLIN		NAME OF ASSISTANT HISTOLOGIST JAMES J. COUGHLIN	
NAME OF PHYSICIAN JAMES J. COUGHLIN		NAME OF ASSISTANT PHYSICIAN JAMES J. COUGHLIN	
NAME OF NURSE JAMES J. COUGHLIN		NAME OF ASSISTANT NURSE JAMES J. COUGHLIN	
NAME OF ATTENDING PHYSICIAN JAMES J. COUGHLIN		NAME OF ASSISTANT PHYSICIAN JAMES J. COUGHLIN	
NAME OF PATHOLOGIST JAMES J. COUGHLIN		NAME OF ASSISTANT PATHOLOGIST JAMES J. COUGHLIN	
NAME OF BACTERIOLOGIST JAMES J. COUGHLIN		NAME OF ASSISTANT BACTERIOLOGIST JAMES J. COUGHLIN	
NAME OF RADIOLOGIST JAMES J. COUGHLIN		NAME OF ASSISTANT RADIOLOGIST JAMES J. COUGHLIN	
NAME OF ANATOMIST JAMES J. COUGHLIN		NAME OF ASSISTANT ANATOMIST JAMES J. COUGHLIN	
NAME OF HISTOLOGIST JAMES J. COUGHLIN		NAME OF ASSISTANT HISTOLOGIST JAMES J. COUGHLIN	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH. IT IS NOT VALID FOR THE PURPOSES OF THE FEDERAL GOVERNMENT. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NEW YORK. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF PENNSYLVANIA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF OHIO. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF INDIANA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF ILLINOIS. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF MISSOURI. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF KANSAS. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NEBRASKA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF MINNESOTA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF WISCONSIN. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF MICHIGAN. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF OHIO. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF INDIANA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF ILLINOIS. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF MISSOURI. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF KANSAS. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NEBRASKA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF MINNESOTA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF WISCONSIN. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF MICHIGAN.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09062

9099

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Dor</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Secretary</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Main</u>			
3. NAME OF DECEASED (Type or print) <u>Susan Stevens Hurley</u>				4. DATE OF DEATH <u>8/18</u> 19 <u>60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/6/1872</u>	
9. AGE (If years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. COUNTRY OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wilbur Newton</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Stevens</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Charles W. Hurley, East New Market</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery sclerosis</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>20 days</u> <u>30 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7/17</u> 19 <u>60</u> , to <u>8/18</u> 19 <u>60</u> , that I last saw the deceased alive on <u>8/18</u> 19 <u>60</u> , and that death occurred at <u>7 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. H. Hanks</u> M.D.				ADDRESS (Street, city or town, state) <u>104 Locust St., Cambridge, Md.</u>			
DATE SIGNED <u>8/21/60</u>							
PHYSICIAN'S NAME (Type) <u>W. H. HANKS, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8/21/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>	
22d. LOCATION (City, town, or county) (State) <u>East New Market, Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Keith S. Mulroughy</u>				ADDRESS <u>East New Market</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 26 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Kneale</u>							

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A1SME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge, rural c. LENGTH OF STAY IN tb 2 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eastern Shore State Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton d. STREET ADDRESS none e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles C. Ivens				4. DATE OF DEATH Month August Day 26th Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 24th. 1877	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired store keeper				10b. KIND OF BUSINESS OR INDUSTRY Retail		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Ivens				14. MOTHER'S MAIDEN NAME Alinda Ivens (nee Sinms)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or date of service) No		16. SOCIAL SECURITY NO. 220-32-9641		17. INFORMANT Records of Eastern Shore State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Broncho-pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio-vascular Renal disease DUE TO (c) Arteriosclerosis Generalized INTERVAL BETWEEN ONSET AND DEATH 48 hrs ? ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Inter trochanteric fracture left Femur on 8/2/60							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. #		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Slipped on the tile floor and fell breaking his hip					
20c. TIME OF INJURY Month, Day, Year 3:30 a.m. Aug. 2nd. 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Eastern sh. st. Hosp. Cambridge. Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Eldridge H. Wolff				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Eldridge H. Wolff, M. D. Cambridge, Md.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Aug. 29, 1960		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery	
23. FUNERAL DIRECTOR J. W. Wells				22d. LOCATION (City, town, or country) (State) Chestertown, Maryland			
24e. REC'D BY REGISTRAR AUG 30 '60				24b. REGISTRAR'S SIGNATURE Charles S. Kneass			

09063

14X-2

(M) 016

1

MEDICAL CERTIFICATION

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1 -
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9101 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09064
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GIRDLE TREE</u>	
c. LENGTH OF STAY IN 1b <u>3 yrs</u>		d. STREET ADDRESS <u>23X-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>E.S.S. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MAGGIE L. JOHNSON</u>		4. DATE OF DEATH Month <u>AUG</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/17/85</u> yrs. <u>75</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Robert J. Hickman</u>		14. MOTHER'S MAIDEN NAME <u>Betty Coxton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Beulah E.S.S.H.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> <u>903.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>fracture neck femur, r.</u> (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u> <u>2 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>fall to floor</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7</u> or m. <u>6-20-60</u> p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>	20f. (City or town) (County) (State) <u>Cambridge Wor Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr</u>		DATE SIGNED <u>8/13/60</u>	
EXAMINER'S NAME (Type) <u>JOHN MACE JR</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8-16-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>GIRDLE TREE, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Watson</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 17 '60</u>	
ADDRESS <u>POCOMOKE CITY, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraw</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the words "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

9080

CERTIFICATE OF DEATH

Reg. Dist. No. 09065

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland.</u>				c. LENGTH OF STAY IN 1b <u>2 Weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>210 Academy, Street.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Amanda</u> First <u>Bloodsworth</u> Middle <u>Jones</u> Last				4. DATE OF DEATH Month <u>8</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/8/1875</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Maryland.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Bloodsworth</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		(If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Mr. Ernie E. Jones, 210 Academy, St. Cambridge.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u>Hypertension</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>8/9</u> 19 <u>60</u> , to <u>8/9</u> 19 <u>60</u> that I lost saw the deceased alive on <u>8/9</u> 19 <u>60</u> , and that death occurred at <u>12:40</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>104 Locust St Cambridge Maryland</u> DATE SIGNED <u>8/11/60</u> ACTUAL SIGNATURE <u>W. H. Hanks, M.D.</u> M.D. PHYSICIAN'S NAME (Type) <u>W. H. HANKS, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/11/1960.</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemtery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.,</u>				ADDRESS <u>Le Compte Funeral Service, Cambridge, Md.,</u>		24a. REC'D BY REGISTRAR DATE <u>Aug 23 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinner</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate is signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE AND STATE DEPARTMENT OF HEALTH - BALTIMORE, 12

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9102

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 09066

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	c. LENGTH OF STAY IN 1b 12 hours	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wingate	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elon Middle Waye Last Jones		4. DATE OF DEATH Month August Day 16 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/9/81
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 7 Days 16	IF UNDER 24 HRS. Hours 16 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Jones	
14. MOTHER'S MAIDEN NAME Martha Langrall		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.	
16. SOCIAL SECURITY NO. 218-16-7072		17. INFORMANT Eastern Shore State Hospital records.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Accident DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis, generalized (c) Arteriosclerosis, generalized DUE TO cause lost (c) Arteriosclerosis, generalized			INTERVAL BETWEEN ONSET AND DEATH 8 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Carcinoma of tongue			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None.	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Eldridge H. Wolff		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Eldridge H. Wolff, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/19/1960	22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial
22d. LOCATION (City, town, or county) Cambridge, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.		24a. REC'D BY REGISTRAR DATE AUG 23 '60	
		24b. REGISTRAR'S SIGNATURE Living S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the words "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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9103

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09067

1. PLACE OF DEATH o. COUNTY <u>DORCHESTER</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CAMBRIDGE</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSP.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <u>MARYLAND</u> b. COUNTY <u>NONE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>3307 SOUTHERN AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ERWIN</u> <u>IGNATIUS</u> <u>KRAMER</u>				4. DATE OF DEATH Month Day Year <u>AUGUST</u> <u>18</u> <u>1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 18, 1898</u>	9. AGE (In years lost birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>RUDOLPH KRAMER</u>			14. MOTHER'S MAIDEN NAME <u>BERTHA SCHMIDT</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT Address <u>RECORDS EASTERN SHORE STATE HOSP.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> <u>440X 260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROTIC CARDIO-RENAL DISEASE</u> DUE TO (c) <u>DIABETES MELLITUS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>14 MOS.</u> <u>17 YRS.</u> <u>9 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <u>JAN 10</u> 19 <u>45</u> , to <u>AUG 18</u> , 19 <u>60</u> , that (X) (we) last saw the deceased alive on <u>AUG 16</u> , 19 <u>60</u> , and that death occurred at <u>4:45</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>George H. Longley</u> 22c. PHYSICIAN'S NAME (Type) <u>GEORGE H. LONGLEY</u>				22b. DATE SIGNED <u>AUG 18, 1960</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
22d. ADDRESS <u>EASTERN SHORE STATE HOSP.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-22-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		23d. LOCATION (City, town, or county) (State) <u>Balto, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Campbell Cambridge, Md</u> ADDRESS _____				25a. REC'D BY REGISTRAR <u>AUG 23 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>	

BP

9103



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G269 8-25-60 et

CERTIFICATE OF DEATH

09068

Reg. Dist. No.

9104

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Church Creek				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Church Creek			
c. LENGTH OF STAY IN 1b Life				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mattie Middle V. Last Lee				4. DATE OF DEATH Month Aug. Day 11 Year 1960			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 4, 1899	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 6 Days 21 Hours 11 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Laborer		11. BIRTHPLACE (State or foreign country) Dorchester County, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George Carr				14. MOTHER'S MAIDEN NAME Jane Meekins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-20-4969		17. INFORMANT Luther Carr, Linas Road, Dor. Co., Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior-splenic CVD & failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Anterior-splenic aneurysm DUE TO (c) ?				INTERVAL BETWEEN ONSET AND DEATH 2 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old residual of hemiplegia				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan , 19 60 to Aug 11 , 19 60 , that I last saw the deceased alive on Aug 10 , 19 60 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cambridge, Md DATE SIGNED Aug 15, 60							
ACTUAL SIGNATURE J. W. Thompson M.D.							
PHYSICIAN'S NAME (Type) J. W. Thompson							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/14/1960		22c. NAME OF CEMETERY OR CREMATORY Linas Road Cemetery		22d. LOCATION (City, town, or county) (State) Dorchester County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hubert H. Sullivan				24a. REC'D BY REGISTRAR Cambridge, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Knapp	

CERTIFICATE OF DEATH

9104

1. NAME OF DECEASED JAMES M. SMITH		2. SEX Male	
3. AGE 45		4. RACE White	
5. DATE OF BIRTH Jan 15, 1900		6. PLACE OF BIRTH Baltimore, Md.	
7. DATE OF DEATH Jan 20, 1945		8. PLACE OF DEATH Baltimore, Md.	
9. TIME OF DEATH 10:30 AM		10. CAUSE OF DEATH Myocardial Infarction	
11. DISEASE OR INJURY Coronary Artery Disease		12. MANNER OF DEATH Natural	
13. SIGNATURE OF PHYSICIAN J. H. Smith, M.D.		14. SIGNATURE OF REGISTRAR J. H. Smith, M.D.	
15. SIGNATURE OF WITNESSES J. H. Smith, M.D.		16. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
17. SIGNATURE OF WITNESSES J. H. Smith, M.D.		18. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
19. SIGNATURE OF WITNESSES J. H. Smith, M.D.		20. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
21. SIGNATURE OF WITNESSES J. H. Smith, M.D.		22. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
23. SIGNATURE OF WITNESSES J. H. Smith, M.D.		24. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
25. SIGNATURE OF WITNESSES J. H. Smith, M.D.		26. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
27. SIGNATURE OF WITNESSES J. H. Smith, M.D.		28. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
29. SIGNATURE OF WITNESSES J. H. Smith, M.D.		30. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
31. SIGNATURE OF WITNESSES J. H. Smith, M.D.		32. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
33. SIGNATURE OF WITNESSES J. H. Smith, M.D.		34. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
35. SIGNATURE OF WITNESSES J. H. Smith, M.D.		36. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
37. SIGNATURE OF WITNESSES J. H. Smith, M.D.		38. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
39. SIGNATURE OF WITNESSES J. H. Smith, M.D.		40. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
41. SIGNATURE OF WITNESSES J. H. Smith, M.D.		42. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
43. SIGNATURE OF WITNESSES J. H. Smith, M.D.		44. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
45. SIGNATURE OF WITNESSES J. H. Smith, M.D.		46. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
47. SIGNATURE OF WITNESSES J. H. Smith, M.D.		48. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
49. SIGNATURE OF WITNESSES J. H. Smith, M.D.		50. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
51. SIGNATURE OF WITNESSES J. H. Smith, M.D.		52. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
53. SIGNATURE OF WITNESSES J. H. Smith, M.D.		54. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
55. SIGNATURE OF WITNESSES J. H. Smith, M.D.		56. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
57. SIGNATURE OF WITNESSES J. H. Smith, M.D.		58. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
59. SIGNATURE OF WITNESSES J. H. Smith, M.D.		60. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
61. SIGNATURE OF WITNESSES J. H. Smith, M.D.		62. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
63. SIGNATURE OF WITNESSES J. H. Smith, M.D.		64. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
65. SIGNATURE OF WITNESSES J. H. Smith, M.D.		66. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
67. SIGNATURE OF WITNESSES J. H. Smith, M.D.		68. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
69. SIGNATURE OF WITNESSES J. H. Smith, M.D.		70. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
71. SIGNATURE OF WITNESSES J. H. Smith, M.D.		72. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
73. SIGNATURE OF WITNESSES J. H. Smith, M.D.		74. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
75. SIGNATURE OF WITNESSES J. H. Smith, M.D.		76. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
77. SIGNATURE OF WITNESSES J. H. Smith, M.D.		78. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
79. SIGNATURE OF WITNESSES J. H. Smith, M.D.		80. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
81. SIGNATURE OF WITNESSES J. H. Smith, M.D.		82. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
83. SIGNATURE OF WITNESSES J. H. Smith, M.D.		84. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
85. SIGNATURE OF WITNESSES J. H. Smith, M.D.		86. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
87. SIGNATURE OF WITNESSES J. H. Smith, M.D.		88. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
89. SIGNATURE OF WITNESSES J. H. Smith, M.D.		90. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
91. SIGNATURE OF WITNESSES J. H. Smith, M.D.		92. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
93. SIGNATURE OF WITNESSES J. H. Smith, M.D.		94. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
95. SIGNATURE OF WITNESSES J. H. Smith, M.D.		96. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
97. SIGNATURE OF WITNESSES J. H. Smith, M.D.		98. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
99. SIGNATURE OF WITNESSES J. H. Smith, M.D.		100. SIGNATURE OF WITNESSES J. H. Smith, M.D.	



RECEIVED
JAN 21 1945
BALTIMORE, MD.
STATE DEPARTMENT OF HEALTH
BALTIMORE, MD.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9081

09069

1. PLACE OF DEATH a. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dorchester, Co. c. LENGTH OF STAY IN 1b Cambridge, Maryland. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 109 Muse, Street				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester, Co. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md. d. STREET ADDRESS 109 Muse, Street. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Milbourne R. McNamara First Middle Last				4. DATE OF DEATH 8 11 19 60 Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/16/1889 9. AGE (In years last birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate		10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Mc Namara				14. MOTHER'S MAIDEN NAME Annie Christopher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No.		17. INFORMANT Miss Evah B. Mc Namara Address 109 Muse, St. Cambridge Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis (c) Hypertension							INTERVAL BETWEEN ONSET AND DEATH 7 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/10 19 60 to 8/11 19 60 , that (I) (we) last saw the deceased alive on 8/11 19 60 and that death occurred at 1:30 M. from the causes and on the date stated above.							
22a. SIGNATURE W. H. Hanks MD				22b. DATE SIGNED 8/11/60		22c. PHYSICIAN'S NAME (Type) W. H. HANKS MD	
22d. ADDRESS Cambridge, Maryland				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/12.1960.		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park.		23d. LOCATION (City, town, or county) (State) Cambridge, Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.				25a. RECEIVED BY REGISTRAR AUG 23 1960		25b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

(M)

(I)

(1)

1206



TO MEDICAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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9082
M
067
1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09070

1. PLACE OF DEATH a. COUNTY <u>Dorchester, Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Dorchester, Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland.</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hospital</u>				e. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Grover</u>		First <u>Cleveland</u> Middle <u>Riggins</u> Last		4. DATE OF DEATH Month <u>8</u> Day <u>21</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/22/1884</u>	
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>75</u> Days <u>75</u> Hours <u>75</u> Min.		IF UNDER 24 HRS. Months <u>75</u> Days <u>75</u> Hours <u>75</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>		11. BIRTHPLACE (State or foreign country) <u>Fishing Creek, Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Scott Riggins</u>				14. MOTHER'S MAIDEN NAME <u>Jane Shenton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Mrs. Buena Newcomb,</u>		Address <u>1430 Sunset Ave, Utica, N.Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Extrahepatic Biliary obstruction</u> DUE TO (c) <u>Carcinoma of bile duct</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 17, 1960</u> to <u>Aug 21, 1960</u> that (I) <u>last</u> saw the deceased alive on <u>Aug 21, 1960</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Lewis M. Burdette</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Aug 23, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lewis M. Burdette</u>				22d. ADDRESS <u>1 Locust St. Cambridge, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/24, 1960.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.</u>				25a. RECEIVED BY REGISTRAR DATE <u>AUG 31 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9083 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09071

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b 10 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge-Maryland Hospital				e. STREET ADDRESS R.F.D. 1			
3. NAME OF DECEASED (Type or print) First Ruth Middle Holland Last Robbins				4. DATE OF DEATH Month August Day 18 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 11, 1919	
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months 41 Days 18 Hours 19		10. BIRTHPLACE (State or foreign country) Baltimore		11. CITIZEN OF WHAT COUNTRY? U.S.	
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				12b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Robert B. Holland				14. MOTHER'S MAIDEN NAME Alta Gauer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Vernon E. Robbins, Cambridge, Md., R.D. 1			
17. INFORMANT Vernon E. Robbins, Cambridge, Md., R.D. 1				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 10 hrs.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
21c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		21d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		21f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Mace Jr.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John Mace Jr. M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 8/22/60			
				DATE SIGNED			
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF August 20, 1960		22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		22d. LOCATION (City, town, or country) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR Kenneth R. Shover				ADDRESS Cambridge, Md.			
24a. REC'D BY REGISTRAR AUG 23 '60				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9084

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10230

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Cambridge</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Maryland Hospital</u>			d. STREET ADDRESS <u>RFD 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Baby Melvin Sharps</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>14</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27, 1960</u>		9. AGE (In years last birthday) yrs. <u>2</u> Months <u>17</u> Days <u>17</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester County, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Leroy Sharp</u>		
14. MOTHER'S MAIDEN NAME <u>Esther Thompson</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Leroy Sharp, RFD 2, Cambridge, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia</u> <u>527.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute respiratory infection</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 days</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John Msch Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8/15/60</u>	
EXAMINER'S NAME (Type) <u>John Msch Jr. M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/15/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Thompson town Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>		ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 4 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

40-5279XV4

11530

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9084

FOR STATE
HEALTH

PLACE OF DEATH

HOSPITAL

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

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TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9085

CERTIFICATE OF DEATH

Reg. Dist. No. 10232

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 12 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 215 B Cedar Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mimmie Middle Dorman Last Stanley		4. DATE OF DEATH Month August Day 30 Year 19 60	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 25, 1890
9. AGE (In years last birthday) 69		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Wicomico County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Tamter Dorman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
INFORMANT Richard Stanley, Cambridge, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443 X IMMEDIATE CAUSE (a) Cardiovascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 10, 19 59 to August 30 19 60 that I last saw the deceased alive on August 30, 19 60 , and that death occurred at 1:45 P. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 227 Pine St-Cambridge, Md. 9-1-60			
ACTUAL SIGNATURE J. Edwin Fassett		M.D. 227 Pine St-Cambridge, Md. 9-1-60	
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 3, 1960	
22c. NAME OF CEMETERY OR CREMATORY Head of the Creek Cemetery near White Haven, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		ADDRESS DATE SEP 8 '60	
24a. REC'D BY REGISTRAR Charles S. Klaus		24b. REGISTRAR'S SIGNATURE	

STATE OF NEW YORK
IN SENATE
January 10, 1902
REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1899
ALBANY: J. B. LIPPINCOTT & CO., PRINTERS.
1902.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9105

CERTIFICATE OF DEATH

09072

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna - Rural		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 50		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Winfield Middle Stanley Last Stanley		4. DATE OF DEATH Month August Day 29 Year 19 60	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1892
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Henry Stanley		14. MOTHER'S MAIDEN NAME Mary (maiden name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-07-9981	
17. INFORMANT Mrs. Sarah L. Stanley, Vienna, Md., R.F.D.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4-20-60 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 3 days years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 4, 1960 to Aug 29, 1960 , that I last saw the deceased alive on Aug 29, 1960 , and that death occurred at 5:15 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE JASON F. G. YEEMD.		ADDRESS (Street, city or town, state) HURLOCK, Maryland	
PHYSICIAN'S NAME (Type) JASON F. G. YEEMD.		DATE SIGNED 8/31/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 31, 1960	
22c. NAME OF CEMETERY OR CREMATORY Fork Neck Cemetery		22d. LOCATION (City, town, or county) (State) Near Vienna, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE SEP 6 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

1000



1010

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9086 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09073

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester, Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester, Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland.</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Maryland Hospital.</u>		d. STREET ADDRESS <u>None</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bertha Elliott Travers</u>		4. DATE OF DEATH Month Day Year <u>8 11 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/22/1931</u>
9. AGE (In years last birthday) <u>29</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>29</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Fishing Creek, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Elliott</u>		14. MOTHER'S MAIDEN NAME <u>Nettie Travers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mr. Riley Travers, Fishing Creek, Maryland.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture cerebral aneurysm</u> 452X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <u>8/12/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/14/1960.</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park, Cambridge, Maryland.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Maryland.</u>		24a. REC'D BY REGISTRAR <u>AUG 23 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9087 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09074

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester, Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester, Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland.</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fishing Creek, Maryland.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nancy J. Travers</u>		4. DATE OF DEATH Month Day Year <u>8 12 19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/12/1881</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sea Food</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sea Food</u>	
11. BIRTHPLACE (State or foreign country) <u>Fishing Creek, Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Travers</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Lewis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mr. Henry Travers, Fishing Creek, Maryland.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John Mace Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8/12/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/13/1960.</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park.</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 23 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9088

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09075

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>10 Minutes</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3Y01-4</u>		d. STREET ADDRESS <u>St. Paul & 27th St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge Maryland Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ferdinand</u> <u>Long</u> <u>Ulman</u>				4. DATE OF DEATH Month Day Year <u>Aug.</u> <u>22</u> <u>19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 6, 1877</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pharmacy</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown Simon Ulman</u>				14. MOTHER'S MAIDEN NAME <u>Unknown Caroline</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-07-8243</u>		17. INFORMANT <u>Bernard Ulman Baltimore, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. } DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 Hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Mace Jr.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John Mace Jr. M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8/22/60</u>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/24/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Hurlock, Dor., Md.</u>	
23. FUNERAL DIRECTOR <u>Ruth Willoughby</u>				24a. REC'D BY REGISTRAR <u>AUG 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frawley</u>	

MEDICAL CERTIFICATION

118072

9089

FOR THE
BUREAU



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9089

CERTIFICATE OF DEATH

Reg. Dist. No. 10237

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>428 High Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sinia</u> Middle <u>Lolley</u> Last <u>Ward</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>31</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1895</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Josiah Hughes</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Jane Hughes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Oneida Jolley, Cambridge, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February, 1959</u> , to <u>August 31, 1960</u> , that I last saw the deceased alive on <u>August 31, 1960</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>227 Pine St-Cambridge, Md.</u> DATE SIGNED <u>9-1-60</u> ACTUAL SIGNATURE <u>J. Edwin Fassett</u> M.D. PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/4/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Clair Fur. Home</u>		ADDRESS <u>Cambridge, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knead</u>	

9090

CERTIFICATE OF DEATH

09076

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> <u>16322</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hospital</u>				d. STREET ADDRESS <u>2726 74th Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Irving</u> Middle <u>Fulmer</u> Last <u>Wilkinson</u>				4. DATE OF DEATH Month <u>August</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-28-60</u>		9. AGE (In years lost birthday) yrs. <u>—</u>		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>9</u> Min. <u>11</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Irving Fulmer Wilkinson Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Debra Ann Neal</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Debra Ann Wilkinson</u> Address <u>2726 74th Avenue Hyattsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>126 133</u> DUE TO <u>776X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-28</u> , 19 <u>60</u> , to <u>8-28</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8-28</u> , 19 <u>60</u> , and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>8-29-60</u>							
ACTUAL SIGNATURE <u>W. B. Baumann</u> M.D. <u>—</u>							
PHYSICIAN'S NAME (Type) <u>Dr. Wilbur N. Baumann -3- Church Street - Cambridge, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>8-29-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cambridge Maryland Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR DATE <u>SEP 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2067222XV0

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF PHYSICIAN</p>		<p>15. SIGNATURE OF CORONER</p>		<p>16. SIGNATURE OF JURY</p>	
<p>17. SIGNATURE OF DECEASED</p>		<p>18. SIGNATURE OF WITNESS</p>		<p>19. SIGNATURE OF PHYSICIAN</p>		<p>20. SIGNATURE OF CORONER</p>	
<p>21. SIGNATURE OF DECEASED</p>		<p>22. SIGNATURE OF WITNESS</p>		<p>23. SIGNATURE OF PHYSICIAN</p>		<p>24. SIGNATURE OF CORONER</p>	
<p>25. SIGNATURE OF DECEASED</p>		<p>26. SIGNATURE OF WITNESS</p>		<p>27. SIGNATURE OF PHYSICIAN</p>		<p>28. SIGNATURE OF CORONER</p>	
<p>29. SIGNATURE OF DECEASED</p>		<p>30. SIGNATURE OF WITNESS</p>		<p>31. SIGNATURE OF PHYSICIAN</p>		<p>32. SIGNATURE OF CORONER</p>	
<p>33. SIGNATURE OF DECEASED</p>		<p>34. SIGNATURE OF WITNESS</p>		<p>35. SIGNATURE OF PHYSICIAN</p>		<p>36. SIGNATURE OF CORONER</p>	
<p>37. SIGNATURE OF DECEASED</p>		<p>38. SIGNATURE OF WITNESS</p>		<p>39. SIGNATURE OF PHYSICIAN</p>		<p>40. SIGNATURE OF CORONER</p>	
<p>41. SIGNATURE OF DECEASED</p>		<p>42. SIGNATURE OF WITNESS</p>		<p>43. SIGNATURE OF PHYSICIAN</p>		<p>44. SIGNATURE OF CORONER</p>	
<p>45. SIGNATURE OF DECEASED</p>		<p>46. SIGNATURE OF WITNESS</p>		<p>47. SIGNATURE OF PHYSICIAN</p>		<p>48. SIGNATURE OF CORONER</p>	
<p>49. SIGNATURE OF DECEASED</p>		<p>50. SIGNATURE OF WITNESS</p>		<p>51. SIGNATURE OF PHYSICIAN</p>		<p>52. SIGNATURE OF CORONER</p>	
<p>53. SIGNATURE OF DECEASED</p>		<p>54. SIGNATURE OF WITNESS</p>		<p>55. SIGNATURE OF PHYSICIAN</p>		<p>56. SIGNATURE OF CORONER</p>	
<p>57. SIGNATURE OF DECEASED</p>		<p>58. SIGNATURE OF WITNESS</p>		<p>59. SIGNATURE OF PHYSICIAN</p>		<p>60. SIGNATURE OF CORONER</p>	
<p>61. SIGNATURE OF DECEASED</p>		<p>62. SIGNATURE OF WITNESS</p>		<p>63. SIGNATURE OF PHYSICIAN</p>		<p>64. SIGNATURE OF CORONER</p>	
<p>65. SIGNATURE OF DECEASED</p>		<p>66. SIGNATURE OF WITNESS</p>		<p>67. SIGNATURE OF PHYSICIAN</p>		<p>68. SIGNATURE OF CORONER</p>	
<p>69. SIGNATURE OF DECEASED</p>		<p>70. SIGNATURE OF WITNESS</p>		<p>71. SIGNATURE OF PHYSICIAN</p>		<p>72. SIGNATURE OF CORONER</p>	
<p>73. SIGNATURE OF DECEASED</p>		<p>74. SIGNATURE OF WITNESS</p>		<p>75. SIGNATURE OF PHYSICIAN</p>		<p>76. SIGNATURE OF CORONER</p>	
<p>77. SIGNATURE OF DECEASED</p>		<p>78. SIGNATURE OF WITNESS</p>		<p>79. SIGNATURE OF PHYSICIAN</p>		<p>80. SIGNATURE OF CORONER</p>	
<p>81. SIGNATURE OF DECEASED</p>		<p>82. SIGNATURE OF WITNESS</p>		<p>83. SIGNATURE OF PHYSICIAN</p>		<p>84. SIGNATURE OF CORONER</p>	
<p>85. SIGNATURE OF DECEASED</p>		<p>86. SIGNATURE OF WITNESS</p>		<p>87. SIGNATURE OF PHYSICIAN</p>		<p>88. SIGNATURE OF CORONER</p>	
<p>89. SIGNATURE OF DECEASED</p>		<p>90. SIGNATURE OF WITNESS</p>		<p>91. SIGNATURE OF PHYSICIAN</p>		<p>92. SIGNATURE OF CORONER</p>	
<p>93. SIGNATURE OF DECEASED</p>		<p>94. SIGNATURE OF WITNESS</p>		<p>95. SIGNATURE OF PHYSICIAN</p>		<p>96. SIGNATURE OF CORONER</p>	
<p>97. SIGNATURE OF DECEASED</p>		<p>98. SIGNATURE OF WITNESS</p>		<p>99. SIGNATURE OF PHYSICIAN</p>		<p>100. SIGNATURE OF CORONER</p>	

NEW YORK STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 9091 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09077

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN lb 3 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge-Maryland Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Vernon Wingate				4. DATE OF DEATH August 11, 1960 19 9th. Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 16, 1897 62 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wingate, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Alfred J. Wingate				14. MOTHER'S MAIDEN NAME Sarah Jones			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Hardesty Wingate, Travers Court, Cambridge, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial injury DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)							INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was riding bicycle and ran into auto.					
20c. TIME OF INJURY Month, Day, Year Hour e.m. 4 PM 8-6-1960		20d. INJURY OCCURRED While et work <input checked="" type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Cambridge Dor. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John Ace Jr.</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John Ace Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 8/10/60			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 11, 1960		22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		22d. LOCATION (City, town, or country) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR <i>Emmett R. Thoreson</i> ADDRESS Cambridge, Md.				24a. REC'D BY REGISTRAR AUG 15 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thoreson</i>	

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MEDICAL CERTIFICATION

TO WHOM IT MAY CONCERN



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND

9106

CERTIFICATE OF DEATH

09078

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harlock</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Asker Nursing Home</u>		d. STREET ADDRESS <u>05X-2</u>	
3. NAME OF DECEASED (Type or print) <u>Mapel</u> First <u>Greenwalt</u> Middle <u>Woodward</u> Last		4. DATE OF DEATH <u>8</u> / <u>15</u> / <u>1960</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/4/1890</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Joseph Woodward, Federalburg</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420-0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic Heart Disease</u> DUE TO <u>3 month</u> (c) <u>Congestive Heart Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 6, 1960</u> to <u>Aug. 15, 1960</u> , that I last saw the deceased alive on <u>August 15, 1960</u> , and that death occurred at <u>5:00 A.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jason Yee</u> M.D.		ADDRESS (Street, city or town, state) <u>Harlock, Maryland</u> DATE SIGNED <u>8/15/60</u>	
PHYSICIAN'S NAME (Type) <u>JASON YEE, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/17/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		22d. LOCATION (City, town, or county) (State) <u>East New Market, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Thomas</u> ADDRESS <u>East New Market</u>		24. REG'D BY REGISTRAR DATE <u>AUG 18 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

